

FACILITY ADMISSION NOTICE

See Instructions on Reverse Side

Michigan Department of Community Health

1. Patient Name (<i>Last, First, Middle</i>)			2. Gender <input type="checkbox"/> M <input type="checkbox"/> F		3. Birth Date		4. Social Security No.	
5. Home Address (No. & Street)			City			State		ZIP Code
6. Name of Person Responsible for Patient (<i>Last, First, Middle</i>)			7. Phone No.			8. Relationship to Patient		
9. Home Address (No. & Street)			City			State		ZIP Code
10. Name of Provider			12. Provider ID No.					
11. Provider Address (No. & Street)			13. Attending Physician Name					
City		State	ZIP Code		14. Hospital Case No. (If Applicable)			
15. Type of Facility: (<i>Check ONE</i>) <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care in Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> OTHER (Explain): <input type="checkbox"/> Special MR Nursing Home <input type="checkbox"/> ICF / MR Care in a DCH Facility <input type="checkbox"/> ICF / MR Care in an AIS Facility <input type="checkbox"/> Medical Care Facility <input type="checkbox"/> Psychiatric Care in a DCH Facility (Name of AIS Facility): _____								
16 Date of Admission		17. If LTC Facility, Specify Private Rate \$ _____ per diem		18. Is this Admission Likely to be 30 days or Longer? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, Estimate Total Length of Stay): _____				
19. Present Status of Patient <input type="checkbox"/> Still a Patient <input type="checkbox"/> Discharged (Date): _____ <input type="checkbox"/> Deceased (Date): _____								
20. Primary Diagnosis				21. Secondary Diagnosis				
22. Patient Admitted to Facility From: (<i>Check ONE</i>) <input type="checkbox"/> HOME <input type="checkbox"/> Long Term Care Facility or Unit <input type="checkbox"/> AFC or Home for the Aged <input type="checkbox"/> OTHER (Specify): <input type="checkbox"/> HOSPITAL (Enter applicable dates) ⇒ Admission Date: _____ Discharge Date: _____								
23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable <input type="checkbox"/> MEDICARE <input type="checkbox"/> NO Other Insurance Coverage Available <input type="checkbox"/> Private Health Insurance (Complete Items 24 thru 29 below) <input type="checkbox"/> Private LTC Coverage (Complete Items 30 thru 35 below)								
24. Name of Policyholder (Private Health Ins.)		25. Policyholder's SS No.		30. Name of Policyholder (Private LTC Ins.)		31. Policyholder's SS No.		
26. Name of Insurance Company				32. Name of Insurance Company				
27. Location (City)		State	ZIP Code		33. Location (City)		State	ZIP Code
28. Group / Policy Number		29. Cert. / Contract No.		34. Group / Policy Number		35. Cert. / Contract No.		
PATIENT CERTIFICATION I certify that the information furnished by me in applying for skilled nursing home, other long term care or hospital services under Michigan Public Acts: 321 of 1966; 280 of 1939; and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in item 10 above, the name(s) and address(es) of all parties liable or who may be liable in whole or part for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible in whole or in part for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.								
36. Signature of Patient or Patient's Representative				Date Signed		37. Signature of Person Completing This Form		Date Signed

STATEMENT OF ELIGIBILITY (To be completed by MDCH / FIA for MA eligibility)

Eligibility is: <input type="checkbox"/> DENIED (Contact Patient or Patient's Representative for Explanation) <input type="checkbox"/> APPROVED (See the Billing Information Below)							
Eligible Person's Name			Program		Grantee Name		
Recipient ID No.		MA Eligibility Effective Date		Grantee Client ID No.		FIA Case No.	
Patient Pay Amount \$		Patient Pay Amt. Effective Date		County	District	Section	Unit
Insurance, Medicare, Third Party Name				Worker Name			
				Signature of Worker			